

# Washington State Health Home Model

## Hypothetical Chronic Care Management Patient Scenario #2

**Patient Background: “Oscar”:** Oscar is age 41, 5’3” and 190 lbs. Oscar was diagnosed with Down’s syndrome shortly after birth. As an adult, Oscar was diagnosed hypothyroidism, high cholesterol, degenerative disc disease, and generalized anxiety disorder. Oscar lives alone in substandard housing. He receives long-term care services including Meals on Wheels, a Personal Response System (PERS), in-home caregiver and Medicaid transportation for medical appointments.

Oscar has limited support from family and friends. In the past, he has had difficulty maintaining safe and affordable housing, difficulty managing his finances and supervising caregivers. He has communication and speech issues which impact his relationships with providers and case managers. Oscar often uses the emergency room when he has medical concerns rather than attempt to make an appointment with the clinic he was assigned to by his managed care organization.

**Engagement and Health Home:** There are 2 pathways to initial engagement with Washington’s Health Homes for Oscar:

1. Based on his chronic conditions and meeting the state’s definition of “at risk for another” (a predictive modeling score of 1.5 or higher), he was auto-enrolled with one of the qualified health home networks in the geographic region in which he resides. He received outreach and education information sent by mail from the state. The health home network assigned him to a local health home care coordination organization who reached out to Oscar to describe the benefits of the service and to determine if he would like to receive health home services.
2. Shortly following Oscar’s ER visit last week, he was added to a list of persons to be actively sought for engagement by a health home network because he had more than two avoidable emergency room visits in the past fifteen months. This referral came through the local emergency room department who has agreed to refer eligible participants to the program.

The lead entity of the health home network assigned the referral to Betty, a health home care coordinator, to contact Oscar and offer care coordination and health home services. Once assigned, the RN care coordinator takes the following steps:

- ✓ Uses the Predictive Risk Intelligence System (PRISM) to review Oscar’s PRISM claims utilization - 15 month history of care provided by Medicaid and/or Medicare. PRISM information includes episode information related to specific diagnoses or pharmacy utilization; inpatient and outpatient claims, emergency room visits and care, mental health claims, alcohol and other drug treatment claims, pharmacy claims and long-term care assessment data.
- ✓ Makes contact with Oscar by phone or mail to arrange a home visit.

- ✓ Sends Oscar a welcome letter and Health Home informational brochure.

The PRISM Health Report indicates that Oscar has not been regularly filling prescriptions for his thyroid or anxiety medications. He has visited a nurse practitioner at his medical clinic twice over the last 15 months, but he has not been to the clinic in the past six months. Oscar has accessed services through the Community Hospital Emergency Room four times in the past six months.

**Client Engagement and Enrollment:** Betty contacted Oscar by telephone and explained that enrollment in health home services is voluntary. Oscar was reluctant to engage with Betty after this first phone call. Based on the information in PRISM and her limited discussion with Oscar, she attempted two home visits. On the second visit, she was able to meet with Oscar and provide him with an understanding of the benefits to participation in Washington's Health Home Services and the services Health Home care coordinator could provide. Oscar decided to participate and she and Oscar agreed to another home visit where she would:

1. Provide an introduction of the program including a description of care coordination and Health Home Services;
2. Complete a brief health screening including mental, physical and chemical dependency questionnaires;
3. Evaluates Oscar's support system;
4. Complete a ***Consent for Release of Information***
5. Administer and scores the 13-question ***Patient Activation (PAM) or Caregiver Activation Measure (CAM)***.
  - a. The PAM measures activation and behaviors that underlie activation including ability to self-manage, to collaborate with providers, to maintain function, prevent declines and to access appropriate and high quality health care.
  - b. The PAM helps health home care coordinators to target tools and resources commensurate with the beneficiary's level of activation
  - c. The PAM provides insight into how to improve unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health.

The health home care coordinator notes the following healthcare problems by a combined review of PRISM and the initial home visit with Oscar:

- ✓ Oscar does not have an ongoing relationship with a primary care physician or nurse practitioner at the clinic. He has seen multiple providers at the clinic and is very reluctant to schedule an appointment due to his speech limitation.
- ✓ Oscar uses the Community Hospital emergency room for his medical care, other than routine care scheduled by the clinic.
- ✓ Oscar's health literacy level is low; he does not have a clear understanding of his diagnoses, of his prescribed medications nor the importance of routine medical care. He admits to having difficulty reading discharge instructions from ~~her~~ his recent emergency room visits. He is scored at a low level of activation using the PAM.

- ✓ Oscar has a diagnosis of anxiety, but has does not know when to take his medication and is not aware of triggers that might lead to an increase in anxiety nor can he identify other tools and resources that may help him with anxiety. Oscar is not participating with a mental health provider at this time.
- ✓ Oscar has a limited support system and lives in an area where he feels the neighborhood is unsafe.
- ✓ Oscar is unable to understand his long-term care services and the tasks assigned to his paid provider under his CARE plan. Oscar has refused to allow his caregiver to assist with medication management or to help him schedule medical appointments or access medical transportation.

**Health Action Plan Development:** During the first home visit, the health home care coordinator introduces the ***Health Action Plan (HAP)*** to Oscar; the Health Action Plan helps to guide Oscar towards appropriate choices, attainable goals, action steps and improved health. Together, the care coordinator and Oscar identify immediate and long-term goals, prioritize concerns and establish immediate action steps. Oscar's first goal is to learn more about the services available through his medical clinic and establish better means to contact his provider.

Next, the health home care coordinator and Oscar complete a ***Goal & Action Planning Worksheet*** to describe what steps Oscar would like to take first, to identify possible barriers, his plans to overcome barriers, and to measure how important and how confident he feels about this first goal.

Oscar's immediate goal is to take an orientation tour of his medical clinic. He rates this goal as a "7" on a 1-10 scale of importance; however, he rates his confidence in attaining the goal as a "3" on a 1-10 scale of importance. He and the health home care coordinator work together to develop steps that Oscar can take now and what steps his caregiver and his health home care coordinator will need to take to help with this goal and to increase his level of confidence.

**Care Coordination:** The health home care coordinator contacts the medical clinic and learns that the clinic can assign a patient advocate to work with Oscar. They set up a date and time for Oscar to meet with the patient advocate, tour the facility to help him understand what services are available to him and learn how to access services. The health home coordinator then calls Oscar to share this information with him and asks him if he would allow his caregiver to assist with scheduling medical transportation as well as reminding him of the appointment with the advocate. With his consent, the health home coordinator then speaks with the caregiver who agrees to assist Oscar with the plan.

On the next visit, the health home coordinator discusses the visit with Oscar to get his view on how the visit to the clinic went. Oscar stated he was happy to know he could call the clinic advocate, but still was not sure when or why he would call. He stated he likes going to the ER because "they all know Oscar at the ER!" The health home coordinator talked with Oscar about the pros and cons of using the clinic services versus ER services. Oscar stated he would like to

attend a group at the medical clinic the advocate had talked with him about. Oscar could not remember the name of the group, but found an appointment in his coat pocket to show his health home coordinator. The appointment was for the Chronic Disease Self-Management Program workshop starting the following week. Oscar's health home coordinator was able to provide Oscar with more information about the program and talked with his caregiver as well. Oscar and his caregiver decided to attend the program together when Oscar expressed his concern that he was worried about his speech problem and his difficulty reading.

**Maintenance of Health Action Plan:** The health home care coordinator continues to work with Oscar to promote self-efficacy, review his strengths and successes and to help him achieve his health related goals. After completing the CDSMP workshop, Oscar chose a new health goal: to improve his health by walking each day. He also identified his neighborhood and weather as barriers. After discussing options with him, Oscar decided to join the YMCA where he could safely exercise year around. Oscar also learned ways to cope with anxiety and the importance of taking his medications on time and he developed a friendship with another participant in the group who lives nearby.

After the fourth month, Oscar developed a cough and a fever and was about to call 911 when he remembered his clinic has a nurse he can call at any time. He and his caregiver called the clinic and worked together to describe his symptoms and to understand the steps they needed to take to help Oscar be more comfortable and to schedule an appointment with a nurse practitioner.

Oscar's care coordinator, patient advocate, and care provider continue to work together with Oscar to help him better understand his care needs, options and strengths in an effort to help him better manage his health conditions, increase his participation in his health care, reduce non-emergent ER visits and support him in taking the next steps to better health.